Ambulatory Surgery Center (ASC) Prospective Payment System: 2012 Final Rule

Overview

On Nov. 1, 2011, CMS issued a final rule that will update payment policies and rates for services furnished to Medicare beneficiaries in ambulatory surgical centers (ASCs) beginning Jan. 1, 2012. Comments to the certain sections of the final rule are due Jan. 3, 2012.

The final rule increases payment rates to ASCs by 1.6 percent in calendar year (CY) 2012. This reflects a consumer price index for all urban consumers (CPI-U) estimated at 2.7 percent, minus a 1.1 percent productivity adjustment required by the Patient Protection and Affordable Care Act (PPACA).

The final rule also establishes a quality reporting program for ASCs and adopts five quality measures, including four outcome measures and one surgical infection control measure beginning in CY 2012, for the CY 2014 payment determination. The final rule adds two structural measures for reporting beginning in CY 2013 for the CY 2015 and CY 2016 payment determinations — one for safe surgery checklist use and one for ASC facility volume data on selected ASC surgical procedures.

Significant Policy and Payment Changes for 2012

ASC payment rate updates. CMS will apply a 1.6 percent update to ASC payments for CY 2012. The ASC payment system is updated annually by the consumer price index for all urban consumers, which CMS estimates to be 2.7 percent for CY 2012. Beginning in CY 2011, the PPACA requires any annual update under the ASC payment system to be reduced by a productivity adjustment, which is 1.1 percent for CY 2012.

ASC quality measure reporting. The final rule details a total of eight measures on which ASCs need to report, including a new quality reporting program. To allow CMS and ASCs to more effectively plan for future measurement requirements, the final rule also adopts measures for three subsequent payment determinations.

CMS is adopting five quality measures to be reported by ASCs beginning Oct. 1, 2012, for CY 2014 payment determination. These measures include four outcome and one surgical infection control measure to be reported by ASCs on Medicare claims using quality data codes.

In addition, CMS is adding two structural measures — safe surgical checklist use and ASC facility volume data on selected ASC surgical procedures, beginning with reporting in CY 2013 for the CY 2015 payment determination — as well as one National Healthcare Safety Network (NHSN) infection control measure — influenza vaccination coverage among health-care personnel, beginning with reporting in CY 2014 for the CY 2016 payment determinations.

Additional Payment and Policy Decisions

Services Covered by ASCs. CMS continues to exclude from ASC payments some procedures that are provided in the hospital outpatient department (HOPD) setting, but are deemed unsafe for performance in ASCs. CMS also continues to disallow unlisted procedure codes from being included on the ASC list. Furthermore, CMS does not agree that the frequency that a surgical procedure is performed in an office setting should be included as one of the criteria for inclusion on the ASC list of covered surgical procedures.

Update to the Lists of ASC-Covered Surgical Procedures. CMS reviewed 232 procedures codes for inclusion on the ASC list of covered surgical procedures for 2012. Of those, CMS agreed to include six additional codes that were not GI related. CMS found that the remaining procedures either may be expected to pose a threat to beneficiary safety or require active medical monitoring at midnight following the procedure. Specifically, CMS found that prevailing medical practice called for inpatient hospital stays for beneficiaries undergoing many of the procedures and that some of the procedures directly involve major blood vessels and/or may result in extensive blood loss.

ASC Payment for Covered Surgical Procedures and Covered Ancillary Services. Given the lack of comments on this section, CMS finalized the CY 2012 proposal, without modification, to calculate the CY 2012 final ASC payment rates for ASC-covered surgical procedures according to established methodologies. CMS also did not receive any comments on its CY 2012 proposal to continue the no cost/full credit and partial credit device adjustment policy for ASCs.

Waiver of coinsurance and deductible for certain preventive services. CMS did not change its proposed rule, which provides for coverage of colorectal cancer screening under certain circumstances.

Ancillary services. After consideration of public comments, CMS provided CY 2012 payment for covered ancillary services in accordance with the policies finalized in the CY 2011 outpatient prospective payment system (OPPS)/ASC final rule, with one modification (related to radiology).

In response to a comment regarding ASCs experiencing problems with obtaining payment from several of the ASC contractors for the pass-through device identified by HCPCS code C1749 [endoscope, retrograde imaging/illumination colonoscope device (implantable)], CMS stated that it will remind contractors that payment for HCPCS code C1749 is not packaged into the payment for the associated procedure. However, the local contractor makes final decisions regarding coverage determinations and the payment amount for the pass-through device.

Cost Reporting. CMS did not propose to require ASCs to submit cost data for CY 2012 because, as noted previously in this section and in the CY 2011 OPPS/ASC final rule, CMS continues to believe that the established methodology results in appropriate payment rates for ASCs. Therefore, CMS finalized the proposal not to require cost reporting in the CY 2012 final rule. CMS will keep the commenters' perspectives about collecting cost information from ASCs in mind as they further consider the adequacy of the Medicare ASC payment rates.

Calculating ASC Payment Rates

According to the final rule, the final CY 2012 ASC payment weight scaler is 0.9466. CMS updates the ASC relative payment weights each year using the national OPPS relative payment weights [and Medicare Physician Fee Schedule (MPFS) nonfacility practice expense relative value unit (PE RVU)-based amounts, as applicable] for that same calendar year and uniformly scales the ASC relative payment weights for each update year to make them budget neutral.

ASC Conversion Factor. CMS will apply its established methodology for determining the final CY 2012 ASC conversion factor. The final ASC conversion factor of $42.627 is the product of the CY 2011 conversion factor of $41.939 multiplied by the wage index budget neutrality adjustment of 1.0004 and the MFP-adjusted CPI-U payment update of 1.6 percent.

Using more complete CY 2010 data for this final rule than was available for the proposed rule, CMS calculated a wage index budget neutrality adjustment of 1.0004. Based on updated data, the CPI-U for the 12 month period ending with the midpoint of CY 2012 is now estimated to be 2.7 percent, while the MFP adjustment is 1.1 percent, resulting in an MFP-adjusted CPI-U update factor of 1.6 percent.

ASC Quality Reporting Program

CMS is finalizing the ASC Quality Reporting Program, with data collection to begin on Oct. 1, 2012, for purposes of the CY 2014 payment determination. CMS intends to propose in the CY 2013 OPPS/ASC proposed rule the method for how these payment penalties will be calculated.

ASC Quality Reporting Program Measurement Set. CMS is also finalizing its proposal to adopt quality measures for the CY 2014, CY 2015 and CY 2016 payment determinations.

CMS is finalizing five of the seven claims-based measures proposed for CY 2014 payment determination. These measures, in addition to two structural measures, will be retained for the CY 2015 payment determination. All seven measures, in addition to one NHSN health-care associated infection measure, will be retained for the CY 2016 payment determination. The table below outlines the measures finalized for purposes of the CY 2014-2016 payment determinations.

CMS is also considering a patient experience of care survey for the ASC Quality Reporting Program, and will consider the operational feasibility of allowing voluntary reporting of such a measure in the future.

Finally, CMS is finalizing the proposed Influenza Vaccination Coverage among Healthcare Personnel measure for the CY 2016 payment determination, with a modification. Because the National Quality Forum's final review and endorsement decision are pending with respect to the CDC's revised measure proposal, and at the request of commenters, as discussed above, CMS is changing the data collection timeframe from what it proposed. Data collection via NHSN will begin on Oct. 1, 2014, and continue through March 31, 2015. Details for submission of this measure will be proposed in a future rulemaking.

ASC Quality Reporting Program Measurement Set for the CY 2014, CY 2015 and CY 2016 Payment Determination			
Measure	**CY 2014**	**CY 2015**	**CY 2016**
ASC-1: Patient Burn	√	√	√
ASC-2: Patient Fall	√	√	√
ASC-3: Wrong Site, Wrong Side, Wrong Patient, Wrong Procedure, Wrong Implant	√	√	√
ASC-4: Hospital Transfer/Admission	√	√	√
ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing	√	√	√
ASC-6: Safe Surgery Checklist Use		√	√

ASC Quality Reporting Program Measurement Set for the CY 2014, CY 2015 and CY 2016 Payment Determination				
Measure		**CY 2014**	**CY 2015**	**CY 2016**
ASC-7: ASC Facility Volume Data on Selected ASC Surgical Procedures			√	√
Procedure Category	*Corresponding HCPCS Codes*			
Gastrointestinal	40000 through 49999, G0104, G0105, G0121, C9716, C9724, C9725, 0170T			
Eye				
Nervous System				
Musculoskeletal				
Skin				
Genitourinary				
ASC--- 8: Influenza Vaccination Coverage among Healthcare Personnel				√

Technical Specification Updates and Data Publication. CMS is finalizing a policy to provide technical specifications and links to technical specifications in a specifications manual to be posted on the CMS QualityNet website as well as the CMS website. CMS will follow the same maintenance process used for the Hospital Outpatient Quality Reporting (OQR) Program, including maintenance of the technical specifications for the measures adopted by updating the specifications manual, and updating the detailed instructions and calculations of algorithms as appropriate.

CMS also finalized the policy to follow the same subregulatory process for the ASC Quality Reporting Program as used for the Hospital OQR Program for updates to the technical specifications, including issuing regular manual releases at six month intervals, providing addenda as necessary, and providing at least three months advance notice for substantial changes, such as changes to ICD-9, CPT, National Uniform Billing Committee and HCPCS codes, and at least six months notice for substantive changes to data elements that would require significant systems changes.

Publication of ASC Quality Reporting Program Data. CMS is finalizing its proposed policy to make data that an ASC has submitted for the ASC Quality Reporting Program available on a CMS website after providing an ASC an opportunity to preview the data to be made public. As proposed, these data will be displayed at the CMS Certification Number level.

Requirements for Reporting of ASC Quality Data for the CY 2014 Payment Determination. CMS is finalizing its proposal that to be eligible for the full CY 2014 ASC annual payment update, an ASC must submit complete data on individual quality measures through a claims-based reporting mechanism by submitting the appropriate quality data codes (QDCs) on the ASC's Medicare claims. Further, CMS is finalizing its proposal that data completeness for claims-based measures be determined by comparing the number of claims meeting measure specifications that contain the appropriate QDCs with the number of claims that would meet measure specifications, but did not have the appropriate QDCs on the submitted claim.

As noted above, CMS is deferring the data collection time period for the CY 2014 payment determination to a later date, beginning data collection with services beginning Oct. 1, 2012, rather than Jan. 1, 2012, while maintaining the end date of Dec. 31, 2012. Finally, CMS is finalizing its proposal to consider an ASC as participating in the ASC Quality Reporting Program for CY 2014 payment determination if the ASC includes QDCs specified for the program on their CY 2012 claims relating to finalized measures.

Estimated Impact

The table below shows the estimated effects on aggregate Medicare payments under the revised ASC payment system by surgical specialty or ancillary items and services group. CMS aggregated the surgical HCPCS codes by specialty group, grouped all HCPCS codes for covered ancillary items and services into a single group, and then estimated the effect on aggregated payment for surgical specialty and ancillary items and services groups. The groups are sorted for display in descending order by estimated Medicare program payment to ASCs.

Surgical Specialty Group	Estimated CY 2011 ASC Payments (in Millions)	Estimated CY 2012 Percent Change
Total	$3,369	2%
Eye and ocular adnexa	$1,440	1%
Digestive system	**$685**	**4%**
Nervous system	$431	0%
Musculoskeletal system	$415	2%
Genitourinary system	$149	5%
Integumentary system	$130	1%
Respiratory system	$43	2%
Cardiovascular system	$31	-3%
Ancillary items and services	$29	-26%
Auditory system	$10	-2%
Hematologic & lymphatic systems	$4	5%

The table below shows the estimated impact on aggregate payments for select GI procedures.

Procedure	**Estimated CY 2011 ASC Payments (in millions)**	**Estimated CY 2012 Percent Change**
43239 *Upper GI endoscopy, biopsy*	$155	-1%
45380 *Colonoscopy and biopsy*	$133	4%
45378 *Diagnostic colonoscopy*	$100	4%
45385 *Lesion removal colonoscopy*	$85	4%
G0105 *Colorectal scrn; hi risk ind*	$32	5%
G0121 *Colon CA scrn not hi risk ind*	$25	5%
43235 *Upper GI endoscopy, diagnosis*	$24	-1%
45384 *Lesion remove colonoscopy*	$24	4%

Background

There are approximately 5,000 Medicare-participating ASCs. Since Jan. 1, 2008, ASCs have been paid under a revised system that generally aligns payment in ASCs and HOPDs by basing ASC payment rates on the Ambulatory Payment Classification (APC) relative weights for similar services. Under the revised ASC payment system, CMS also adopted criteria allowing for more procedures and services to be covered when furnished in an ASC.

The revised ASC payment rates were established to reflect the same relativity of resource use among procedures as under the OPPS, taking into consideration the lower costs of surgical procedures performed in ASCs and maintaining budget neutrality in the payment system. In general, the revised ASC payment rate for a covered surgical procedure is based on the APC relative payment weights for the same procedure under the OPPS. However, there are a few exceptions to this rule. For example, for device-intensive procedures (assigned to a subset of the OPPS device-dependent APCs with a device offset percentage greater than 50 percent of the APC cost under the OPPS), ASCs receive the same payment for the device cost as under the OPPS. For ASC procedures that are predominantly performed in physicians' offices, the ASC payment generally is capped at the lesser of the Medicare physician fee schedule non-facility PE RVU-based amount or the payment amount under the standard ASC rate setting methodology.