



## REIMBURSEMENT UPDATE

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# Medicare Payment Rule a Big Win for ASCs

Breaking down the good news for ambulatory surgical centers.

**W**hether it was skimping on their yearly payment updates or refusing them separate reimbursement for device-intensive procedures, Medicare's annual payment rule routinely snubbed and shortchanged ambulatory surgical centers (ASCs). Not this year. Surgery centers came out on top like never before in CMS's 2019 final payment rule for hospital outpatient departments (HOPDs) and ASCs, released last month ([osmag.net/YbFW9b](https://osmag.net/YbFW9b)).

And we're not just talking about ASCs receiving a bigger 2019 rate increase (2.1%) than hospitals (1.35%). From aligning the inflation factors it uses to update payments to lowering the threshold for device-intensive procedures, Medicare's payment policy strongly favors ASCs, perhaps a nod to the agency's desire to shift cases from higher-cost HOPDs to lower-cost ASCs.

"The changes included in this year's rule are among the most significant I have seen in my 8 years with ASCA," says William Prentice, CEO of the Ambulatory Surgery Center Association. "Overall, I would say they demonstrate greater recognition of the quality and value ASCs provide than we have seen in any previous rulemaking."

Key points of the 1,182-page rule:

**1 Equal financial footing.** Let's start with a move that could be a harbinger of site neutrality. CMS will use the same inflation rate to update payments in ASCs as it does in HOPDs, a change ASCA has fought for over the last decade. On average, Medicare pays ASCs less than half (47%) of HOPD rates for the same procedures. Many feel this growing divide exists, in part, because CMS uses different measures to update ASC and HOPD payments.

• **LEVEL PLAYING FIELD** Medicare will use the same measure to update ASC and HOPD payments, a policy change that could shorten the disparity between what CMS reimburses for the same procedures.



CMS had been using the Consumer Price Index (CPI) to update ASC payment rates, a measure that examines the weighted average of prices of a basket of consumer goods and services. Meanwhile, it bases HOPD payment increases on the hospital market basket inflation factor, a measure directly related to the increasing costs of providing medical care that are common to both hospitals and ASCs.

"ASCs use the same staff, services and supplies as hospital outpatient departments," says Mr. Prentice, "so it only makes sense to apply the same inflation rate for our yearly updates."

CMS will use the hospital market basket to update ASC payments for the 5-year period of 2019-2023.

**2 Device-intensive procedures.** As you know, the cost of a device can be a large part of the overall cost of some procedures. If an ASC isn't reimbursed separately for an expensive device, it becomes cost-prohibitive to perform that procedure.

In the final rule, CMS reduced the threshold definition of device-intensive procedures in ASCs from 40% to 30%, another policy change that could encourage migration of these procedures into ASCs. The lower the device threshold, the more likely that the ASC will be able to be paid separately for the

device. Moving forward, if the device portion of the overall procedure equals 30% or more of the total cost of the procedure in the HOPD setting, the total device cost will be included in the reimbursement rate when the procedure is performed in an ASC.

According to the ASCA, the change in the cost threshold for device-intensive procedures from 40% to 30% will result in 131 additional procedures being classified as *device-intensive*, including cardiac contractility modulation systems and dialysis circuits with catheter placements, for example. The approved list of device-intensive procedures will grow from 153 to 277 in 2019, says ASCA.

**3 Revised definition of surgery.** In the rule, CMS revised its definition of “surgery” to account for certain “surgery-like” procedures that are assigned codes outside the CPT surgical range. As a result, 12 cardiac catheterization procedures and 5 more that are generally performed during cardiac catheterization have been added to the list of covered ASC procedures. That really broadens the field for invasive cardiologists to be able to perform an array of procedures in ASCs that had to be performed in HOPDs.

**4 Added procedures remain.** After review of all procedures that were added to the ASC-payable list from 2015 through 2017, CMS decided to keep nearly all of the codes for spine procedures on the list, with only 2 exceptions. That leaves 23 of the newly covered spine procedures remaining that will be covered.

There was some pushback from the hospital side that these were not safely performed in ASCs and should be done in HOPDs. CMS looked at outcomes data and determined that it was safe to perform those spine procedures, so they were left on the ASC-payable list.

**5 Separate payment for non-opioid pain drug.** Prompted by the move in Congress to encourage the use of non-opioid pain medications and discourage the use of opioids, CMS will provide a separate payment for non-opioids that function as a supply when used in a surgical procedure per-

formed in a surgical center — but not in hospitals paid under the Outpatient Prospective Payment System. Currently, Exparel (bupivacaine liposome injectable suspension) is the only drug that CMS says qualifies as an effective alternative to opioids for the immediate post-operative period. During the procedure, surgeons inject Exparel directly into the area of the surgical site.

CMS is also creating a financial incentive to use non-opioids. If you use an opioid pain medication, it's paid for under the set ASC rate. But if you use a non-opioid pain medication, it's paid over and above the set ASC rate, what is called an “average sales price” plus 6%, which is like a wholesale price. The average wholesale price of a 20-mL vial of Exparel is \$285. CMS created the product-specific billing code of C9290 for Exparel.



**6 Quality reporting program pared.** Two of the 8 measures CMS proposed to remove from the quality reporting program were approved. Beginning in 2020, CMS will remove “ASC-8: Influenza Vaccination Coverage Among Healthcare Personnel,” and in 2021 remove, “ASC-10: Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use.”

## What about total joints?

As you might recall, last year CMS let HOPDs perform total joint replacement procedures. No, this year's payment rule didn't add any total joint replacement codes — even though many ASCs around the country are performing arthroplasties on non-Medicare patients. But if this exclusion is the only thing ASCs have to complain about, then the 2019 payment rule was a huge win. **OSM**

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