

AMBULATORY SURGICAL CENTER PPS UPDATES FOR CY 2010

In the November 20, 2009 *Federal Register* (pages 60596—60629), the Centers for Medicare and Medicaid Services (CMS) published the final Ambulatory Surgical Center (ASC) conversion factor and payment rates to the ASC prospective payment system (PPS) for services provided on or after January 1, 2010. A transmittal, R1865-CP, dated December 4, 2009 provides additional information on CY 2010 changes.

1. Payment Update: Regulations require the ASC payment amounts in a calendar year be increased by the percentage increase in the Consumer Price Index for All Urban Consumers (CPI-U) for the 12-month period ending with the midpoint of the year involved. For the 12-month period ending with the midpoint of CY 2010, the CPI-U is 1.2 percent. CMS calculated a wage index budget neutrality adjustment of 0.9996. The final ASC conversion factor of \$41.873 is the product of the CY 2009 conversion factor of \$41.393 multiplied by 0.9996 and the 1.2 percent CPI-U. New Technology Intraocular Lenses (NTIOLs) continue to have a final ASC payment adjustment amount of \$50.00 in CY 2010.

ASC payment rates for have been updated for CY 2010 using the established rate calculation methodologies. Payments for procedures subject to the transitional payment methodology (payment indicators A2 and H8) were calculated using a blend of 75 percent of the proposed CY 2010 ASC rate calculated according to the ASC standard ratesetting methodology and 25 percent of the CY 2007 ASC payment rate. The device-intensive procedure methodology was incorporated when appropriate for procedures assigned ASC payment indicator H8. Procedures assigned payment indicator G2, which are procedures are not subject to the transitional payment methodology were calculated using the ASC standard ratesetting methodology.

2. CPT Code Descriptors: Please be advised that there are several instances in which the descriptor of an existing Category I CPT code is substantially revised for CY 2010 so that it describes a new service or procedure that could have been assigned a new code number by the CPT Editorial Panel. As the new code number would then have been assigned the NI comment indicator, these existing CPT code numbers with substantially revised code descriptors are also being assigned the comment indicator NI. The comment indicator N1 allows for comment on these substantially revised codes. CMS will respond to public comments and finalize the ASC treatment in of all codes with a comment indicator of N1 in the CY 2011 OPSS/ASC final rule.

3. ASC Covered Surgical Procedures: Covered ASC surgical procedures and related ancillary are documented in Addenda AA and BB in the Final Rule. These addenda are available on the CMS web site.

Two HCPCS Level II codes are being deleted effective December 31, 2009. They are: G0392, AV fistula or graft arterial and G0393, AV fistula or graft venous.

In the 2009 final rule, CMS agreed to perform a comprehensive review of the APCs and ASC allowable procedures to identify potentially inconsistent ASC treatment of procedures assigned to a single APC under OPSS. The agency examined 223 excluded surgical procedures that were assigned to the same APCs as one or more ASC covered surgical procedures for 2009. A clinical

review led to the determination that 28 surgical procedures might be appropriate for performance in ASCs and proposed to add them to the 2010 ASC list of covered surgical procedures. CMS found that the remaining 197 excluded procedures would pose significant safety risks to beneficiaries or would be expected to require an overnight stay if provided in ASCs. Therefore, those 197 procedures were not proposed for addition to the 2010 ASC list of covered surgical procedures. The 28 CPT codes that were moved from the excluded list to the allowable list are in Table 62 of the OPPTS/ASC Final Rule:

4. Excluded Surgical Procedures: Excluded surgical procedures are documented in Addendum EE in the OPPTS/ASC Final Rule. This addendum is available on the CMS web site.

Surgical procedures that are removed from the OPPTS inpatient-only list were reviewed for inclusion as an allowable ASC procedure. None of the eight procedures were added to the ASC allowable list for 2010 as CMS felt that they might be expected to pose a significant risk to beneficiary safety in ASCs or require an overnight stay.

5. Ancillary Service: All new HCPCS Level II codes implemented in April and July 2009 for ASCs describe covered ancillary services. These codes represent drugs and biologicals that were eligible for separate payment under OPPTS. Additionally new permanent HCPCS Level II codes were assigned to replace temporary codes effective January 1, 2010. These 23 HCPCS codes are contained in Table 2 of the transmittal. The payment indicator for all drug and biological codes is K2.

6. Payment for Office-based Procedures (Payment Indicators P2, P3, R2): It has been CMS's policy to annually review volume and utilization data and the clinical characteristics for procedures assigned one of the temporary office-based payment indicators—P2, P3, or R2. Data used was from CY 2008.

Three of the ten CPT codes did not have any claims data as the codes were new in CY 2009. Another three procedure codes will retain the temporary office-based designation as the currently available volume and utilization data did not prove adequate basis for determining whether the designation should be made permanent. Another review of the status of these codes will be conducted next year.

Four surgical procedures have been permanently given the office-based payment designation. One of these four procedures is HCPCS Level II code C9728, Placement of interstitial device(s) for radiation therapy/surgery guidance (eg, fiducial markers, dosimeter), other than prostate (any approach), single or multiple. There is no Medicare volume and utilization data in physicians' offices for HCPCS code C9728 since this code is not recognized for payment under the MPFS. However, this code is analogous to CPT code 55876 and CMS is applying the same ASC payment methodology to both codes.

7. Partial and Full Credit for Devices (Payment Status H8, J8): Payment for device-intensive services will be reduced by eliminating all or half of the device portion of the payment when modifier FB or FC is reported. This change is similar to the reduction implemented under OPPTS. The list of procedures to which this reduction policy applies is available in Table 70 with applicable devices in Table 71 of the OPPTS/ASC Final Rule.

8. Implantable Biologicals: In 2009, CMS began packaging payment for all nonpass-through implantable biologicals into payment for the associated surgical procedure. In some cases these implantable biologicals can substitute for implantable nonbiologic devices (such as for synthetic nerve conduits or synthetic mesh used in tendon repair).

A HCPCS code should be reported when billing for a biological for which the HCPCS code describes a product that is solely an implantable device that is surgically implanted or inserted, and is separately payable under the ASC payment system. No HCPCS code should be reported when the implanted biological is packaged and not eligible for separate payment.

When billing for a biological for which the HCPCS code describes a product that may be either used either as an implant or as a nonimplantable device, ASCs should not report the HCPCS code for the product when the biological is used as an implantable device during surgical procedures. The cost of supportive items such as these implants is packaged into payment for the surgical procedures. The cost for the biologicals used during surgical procedures as implantable devices may included in the charge for the procedure.

9. Hospital-Operated ASCs: In August 1982, the initial Medicare ASC payment system was established. ASCs operated by hospitals, like freestanding ASCs, had to meet the applicable ASC conditions for coverage and enter into an agreement with CMS in which CMS accepts the ASC as qualified to furnish ambulatory surgical services. The following additional terms of agreement for an ASC operated by a hospital were also required:

- the agreement is made effective on the first day of the next Medicare cost reporting period of the hospital that operates the ASC
- the ASC participates and is paid only as an ASC, without the option of converting to or being paid as a hospital outpatient department, unless CMS determines there is good cause to do otherwise
- costs incurred by the ASC are treated as a non-reimbursable cost center on the hospital's Medicare cost report

Since then, Medicare adopted both an outpatient prospective payment system for hospitals (OPPS) and a revised ASC payment system. As a result, many of the same surgical procedures may be paid under both payment system with the specific payment determined by the site of the service –hospital or ASC. The difference between payments under the two systems is largely a reflection of the differences in capital and operating costs attributable to whether the entity is an ASC or a hospital outpatient department.

CMS had also revised the provider-based status regulations that outline the requirements for a determination that a facility or an organization has provider-based status as a department or entity of a hospital (main provider). Provider-based status determinations are not made for certain facilities when the outcome of the determination would not affect the methodology used to make Medicare or Medicaid payment, the scope of benefits available, or the deductible or coinsurance liability of a Medicare patient.

CMS is removing the existing language requiring a hospital operated ASC to satisfy CMS that there is good cause for its request to become a provider-based department of a hospital prior to being recognized as such. The agency is specifically removing the language, “without the option of converting to or being paid as a hospital outpatient department, unless CMS determines there is good cause to do otherwise.” (second bullet in the first paragraph)

CMS feels that this will bring the requirements into closer alignment with the provider-based status rules for other facilities or organizations that wish to be integrated with the main provider for payment purposes. While an ASC participating in Medicare would continue to be paid only as an ASC, an ASC would also continue to be able to voluntarily terminate its agreement and a main provider wants to consider the surgical facility a provider-based department of that main provider, the facility must meet the revised provider-based status rules

10. Physician Supervision in the ASC: Historically, Medicare has covered surgical procedures performed in ASCs that have relatively short recovery periods and CMS assumed that physicians were always immediately available to furnish assistance and direction including during the postoperative recovery period. However, CMS has recently revised the Conditions for Coverage to

allow longer stays in ASCs and has greatly expanded the list of covered surgical procedures under the revised ASC payment system. The expanded list includes some covered surgical procedures that may require a prolonged recovery period. These two revisions enable ASCs to provide more clinically complex surgical procedures. The complexities, concern for patient safety and the quality of care leads CMS to consider establishing requirements for physician supervision in ASCs, similar to the requirements for the direct supervision of hospital outpatient therapeutic services. CMS is requesting comments on the issue of physician supervision of ASC services, especially as related to extended postoperative stays

11. Quality Reporting: The Medicare Improvements and Extension Act under Division B, Title I of the Tax Relief Health Care Act of 2006, gives the Secretary the authority to implement ASC quality measure reporting and to reduce the payment update for ASCs that fail to report those required measures. CMS did not require ASC quality data reporting for CY 2010, but intends is to implement ASC quality reporting in a future rulemaking.

FOR FURTHER INFORMATION

If you have questions regarding the Medicare Ambulatory Surgical Center Prospective Payment System, please contact our Client Services Department at 1-800-999-DRGS (3747). Be sure to check the Ingenix website (***ingenix.com***) for up-to-date information on other regulatory activities. ***Industry Insights***, as well as source documents and relevant statistics, can be located on the website under “News & Events” (<http://www.ingenix.com/News/Industnews/>). New ***Industry Insights*** are posted on a regular basis, often in advance of formal notification of their availability.