

Dennis Barry's

Reimbursement Advisor

JUNE 2003 • VOLUME 18, NO.10
EDITOR: DENNIS BARRY

CMS Updates List of Approved ASC Procedures

Notice falls short of expectations

by Eric Zimmerman

On March 28, 2003, the Centers for Medicare and Medicaid Services (CMS) published a final rule with comment period in the Federal Register,¹ extending Medicare coverage to nearly 300 surgical procedures when performed in the ambulatory surgery center (ASC) setting. Although the updates were long anticipated and welcomed by the ASC community, this notice fell short of expectations in many respects.

Background: A Long Time Coming

The Social Security Act provisions establishing Medicare coverage for services furnished in ASCs require CMS to identify services that are acceptable for the ASC setting and that will be covered (providing other program requirements are met) when performed in the ASC setting.² Only procedures expressly identified by CMS, commonly referred to as the "ASC List," will be covered by Medicare when furnished to beneficiaries in the ASC setting.

The same statutory provisions likewise require CMS to review and update the ASC List every two years.³ Despite this statutory mandate and considerable pressure from the ASC community, CMS last updated the list of ASC procedures in 1995.⁴

On June 12, 1998, CMS, then the Health Care Financing Administration, published a proposed rule in the Federal Register⁵ proposing to add 422 procedures to the ASC List (and delete 203 current procedural terminology (CPT) codes), a move that

would have expanded the ASC List to include nearly 2,500 procedure codes. The proposed rule, however, also proposed to rebase Medicare payment rates for ASC services, replace the current procedure classification system with the ambulatory payment classification (APC) system (which later would be used to classify hospital outpatient services), and revise the criteria used to determine whether procedures are appropriate for the ASC setting, among other things.

Congress twice took action to block CMS from implementing the proposed payment rate changes contained within the 1998 proposed rule, first with provisions in the Balanced Budget Refinement Act of 1999⁶ and then again with provisions in the Medicare, Medicaid, and Supplemental Children's Health Insurance Programs (SCHIP) Benefits Improvement and Protection Act of 2000.⁷ The changes mandated by the two acts, combined with the diversion of resources necessitated by the year 2000 compliance activities and implementation and startup issues related to the hospital outpatient prospective payment system, led CMS to delay issuing a final ASC rule to implement the ASC List changes and other aspects of the June 1998 proposed rule.

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ASC List Changes: What's On and What's Not

The notice published on March 28, 2003, finalizes aspects of the June 1998 proposed rule, but also leaves many other pieces of the original proposal unresolved. Specifically, the final rule finalizes only CMS' proposed changes to the ASC List, adding 288 procedures and deleting 140 procedures.

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Among those added are CPT codes 29848 (wrist arthroscopy with release of transverse carpal ligament), 31081, 31085, and 31087 (frontal sinusotomy), 52647 (laser coagulation of prostate), and 66825 (repositioning intraocular lens). The additional procedures will give ASCs greater flexibility to furnish a wider array of surgical cases.

Also noteworthy are the procedures CMS initially proposed to delete, but which will now remain on the ASC List, at least for the time being. These include three urodynamic procedures—51726, 51772, and 51785—and four nerve block injection procedures—64420, 64421, 64622, and 64623—which were the subject of numerous comments and intense lobbying by interested stakeholders.

Disappointing to many in the ASC community was CMS' decision to finalize only procedure additions and deletions that the agency proposed in 1998, and to add new CPT codes that were added to CPT between 1999 and 2003 that are similar to procedures on the updated ASC List. CMS did not at this time consider any of the hundreds of other procedure codes that the ASC community recommended be added through comments submitted during the comment period. CMS claims to have received more than 13,000 comments in response to the 1998 proposed rule, a shocking number given that there are only approximately 3,400 Medicare certified ASCs.

Also troubling to many in the ASC community was CMS' decision to not add many procedures it had previously proposed to add because "they would be significantly overpaid in the lowest ASC payment group."⁸ At present, all procedures are classified among one of nine payment groups, which range in service payments from a low of \$333 (group 1) to a high of \$1,339 (group 9) (before adjustments to reflect geographic cost variations). In the 1998 proposed rule, CMS proposed to replace the current procedure classification system

with the APC system, which would have categorized procedures among more than 100 payment groups, and range procedure payments from a low of approximately \$50 to a high of approximately \$2,100. CMS elected to exclude many procedures that it proposed to add, and that otherwise are appropriate for the ASC setting, but for which CMS proposed to pay significantly less than \$333. CMS expressed concern that paying \$333 for these procedures "could create an incentive to shift these procedures to an ASC setting."⁹

Unfinished Business: The Long Road Ahead

Just as noteworthy as the changes made under the March 28 final rule are the many proposals from 1998 that remain unresolved. For example, CMS is not now rebasing ASC payment rates, despite several statutory mandates that CMS do so, including one that requires CMS to implement rebased rates by January 1, 2003, based on a survey conducted no earlier than 1999. CMS allowed the implementation date to pass without action and has not initiated a survey that would be necessary to collect more current data.

Although not included in this rule, reimbursement changes likely are not far off. CMS has been coming under increasing criticism for neglecting the ASC benefit. In February 2003, the Department of Health and Human Services' Inspector General criticized CMS for irrational disparities between ASC and hospital outpatient department payment rates and recommended that CMS equalize payments between the two settings. The following month, the Medicare Payment Advisory Commission raised similar concerns and recommendations.

CMS also did not implement the 1998 proposal to replace the current procedure classification system with APCs. As a result, CMS classified the nearly 300 new ASC List procedures among the nine payment groups.

Additionally, the final notice does not implement changes CMS proposed in 1998 that would have revised the criteria used to determine whether procedures are appropriate for the ASC List. Presently, CMS employs numeric thresholds based on practice patterns and clinical considerations to determine when a procedure should be added to the ASC List. Specifically, only the procedures satisfying the criteria outlined in the following section may be added to the ASC List.

ASC Procedure Criteria

To be added to the ASC List, the procedure generally does not:

- Exceed 90 minutes of operating time;
- Exceed four hours of recovery or convalescent time;
- Result in extensive blood loss;
- Require major or prolonged invasion of body cavities; or
- Directly involve major blood vessels.

In addition, the procedure generally is performed in:

- A physician's office 50 percent or less of the time; and
- A hospital inpatient department 20 percent or more of the time.

In 1998, CMS proposed to: (1) no longer use the criteria based on time limits on operating, anesthesia, and recovery time; and (2) discontinue using site-of-service (*i.e.*, the 20/50 rule) as the principal determinant of which procedures to add to or delete from the ASC List. These proposed changes were expected to give CMS much greater flexibility to expand the ASC List in the future. CMS did not address these proposed changes in this final notice.

Implementation and Commenting

Although the changes made under this notice are final, CMS will accept and respond to comments on the proposed additions of codes defined by CPT since 1998, and the payment group assignments for all procedures, if comments are received by May 27, 2003. Comments should be sent to CMS at: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1885-FC, P.O. Box 8013, Baltimore, MD, 21244-8013.

The ASC List changes become effective for services furnished on or after July 1, 2003. If history is any guide, however, carriers in some jurisdictions may have difficulty implementing the changes in time. ASCs receiving denials after July 1, 2003, for services added to the ASC List should contact the appropriate Medicare carrier.

Relevance to Hospitals

The changes in this notice apply only to Medicare certified ASCs and do not apply to surgical procedures furnished in hospital outpatient departments or other hospital-based entities. Nonetheless, hospitals in competitive markets should take note of the new procedures and corresponding payment rates and compare those rates to Medicare payments to hospitals for those procedures.

The ASC List changes become effective for services furnished on or after July 1, 2003.

In some instances, hospitals may wish to consider making voluntary beneficiary co-payment reductions to remain price competitive with the ASC, or alternatively illustrate the cost benefit of having certain services furnished in the hospital setting. Similarly, hospitals may want to consider the benefits of establishing ASCs, or converting existing outpatient surgical capacity to an ASC. ■

Notes

1. 68 Fed. Reg. 15,268 *et seq.*
2. Soc. Sec. Act §§ 1832(a)(2)(F)(i) and 1833(i)(1)(A).
3. Soc. Sec. Act § 1833(i)(1).
4. 60 Fed. Reg. 5,185 *et seq.* (Jan. 26, 1995).
5. 63 Fed. Reg. 32,290 *et seq.*
6. *See* § 226, Pub. L. No. 106-113.
7. *See* § 424, Pub. L. No. 106-554.
8. 68 Fed. Reg. at 15,270.
9. *Id.*

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