New quality measures, tight deadline mark CMS payment rule for ASCs

It sounds like déjà vu all over again, as Yogi Berra used to say.

That is likely to be the first reaction of many ambulatory surgery center (ASC) administrators to the Calendar Year 2014 Ambulatory Surgical Center Payment Proposed Rule.

Pay formula unchanged
Medicare payment updates would continue at half the level of hospitals’; the reporting threshold for participation in the quality reporting program remains at 50% of procedures; no new procedures would be added to the list of those eligible for Medicare; and there is an impossibly tight implementation schedule, similar to the schedule renegotiated in 2012.

However, there are also some new twists in the latest version. For example, ASCs would be asked to track and report additional quality measures for specific specialties. The proposed rule also changes the way some procedures are reimbursed by packaging services together.

The Centers for Medicare & Medicaid Services (CMS) released the rule as part of the Outpatient Prospective Payment System (OPPS) Proposed Rule (CS-1601-P) in July. The final version, expected in November, will take effect January 1, 2014, unless CMS reconsiders in light of comments asking for longer time for ASCs to prepare. The new quality measures reported in 2014 would influence payment levels beginning in 2016.

Payment update still based on CPI
In computing the payment update for 2014, CMS continues to use the Consumer Price Index for all urban consumers (US city average) (CPI-U) as projected by the Department of Health and Human Services (HHS). The result is an average update factor of 0.9% for ASCs, though failure to meet quality reporting requirements could reduce the actual payment by 2% for individual ASCs. CMS estimates that with the update, Medicare payments to ASCs will increase nationally by $133 million, that is, they will be 3.51% higher than in 2014.

By contrast, the update factor for hospital outpatient departments (HOPDs) is 1.8%, twice as much as for ASCs. That is because the HOPD payment rate is based on a market basket of goods and services. ASC organizations have long urged CMS to use the same basis for both payment rates.

The proposed rule does not include any new procedures to be covered by Medicare when performed at ASCs, whereas in the past, technology permitted an increasing number of inpatient procedures to be performed in an outpatient setting.

CMS will, however, move both hospital and ASC payment computations in the same direction by creating additional categories of packaging for related services and procedures. These now include anesthesia and image processing, among others.

The move comes as the Patient Protection and Affordable Care Act begins to mandate rewarding health care providers for better outcomes rather than additional treatments.
For 2014, CMS proposes to package 7 additional items with their associated procedures into a single payment:

- drugs used in diagnostic procedures
- drugs and biologicals used in surgical procedures
- certain laboratory tests
- procedures identified by add-on codes
- services now identified by payment status indicator “X” (a way of categorizing procedures on claims)
- diagnostic tests on the bypass list (a list of payment codes that CMS currently bypasses when combining multiple procedure claims into a single claim)
- device removal procedures.

The effect of the rate and packaging changes will vary by ASC depending on the mix of specialties because the actual rate change is different for each procedure (see chart for examples).

### Estimated payments by specialty

<table>
<thead>
<tr>
<th>Surgical specialty group</th>
<th>2013 payments ($ millions)</th>
<th>2014 % change</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total</td>
<td>1,496</td>
<td>1</td>
</tr>
<tr>
<td>Eye &amp; ocular adnexa</td>
<td>1,496</td>
<td>−3</td>
</tr>
<tr>
<td>Digestive system</td>
<td>743</td>
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<tr>
<td>Nervous system</td>
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<tr>
<td>Musculoskeletal system</td>
<td>441</td>
<td>−1</td>
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<tr>
<td>Genitourinary system</td>
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<tr>
<td>Integumentary system</td>
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<td>7</td>
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<tr>
<td>Respiratory system</td>
<td>46</td>
<td>7</td>
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<td>Cardiovascular system</td>
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<td>−2</td>
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<tr>
<td>Ancillary services</td>
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<tr>
<td>Auditory system</td>
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<td>4</td>
</tr>
<tr>
<td>Hematologic &amp; lymphatic</td>
<td>5</td>
<td>17</td>
</tr>
</tbody>
</table>

Source: Federal Register, July 19, 2013, p 673.

### Separate payments for devices

Under the proposed rule, Medicare would continue to pay for devices that ASCs must purchase for their surgical patients, but it also would continue to reduce payments where manufacturers cover some or all of that cost, such as replacement orthopedic implants.

Unlike hospitals, ASCs do not submit itemized claims for supplies and devices. CMS makes an exception for “device-intensive procedures,” which might include procedures requiring cardiac, ophthalmology, and orthopedic implants or laparoscopic instruments.

Under this policy, while the ASC payment rate for a service is a fraction of the HOPD rate, when devices represent more than 50% of the cost of a procedure, payments are equal. If the ASC receives a discount or credit for the device in a device-intensive procedure, payment for the procedure is offset to reflect the lower cost to the ASC. The list of procedures and offset percentages appears in Table 38 of the proposed rule for 2014.

### New quality measures for ASCs

Since October 1, 2012, ASCs have been adding quality reports to Medicare claim forms for certain events and procedures. Many healthcare staff have found tracking these measures, all related to patient safety, useful in planning improvements in training or changes in protocols. Starting in 2014, those quality reports will begin to affect the size of future Medicare payments. The 5 quality measures that will count toward 2014 payments are patient burn, patient fall, wrong-site surgery, unexpected hospital transfer, and timing of prophylactic intravenous antibiotics.

In 2013, ASCs began reporting on 2 additional measures: use of a safe surgery checklist in 2012 (ie, reporting in 2013 on use in 2012 procedures) and 2012 procedure volume in certain specialties. Those reports will affect payments in 2015. Another measure, vaccination of staff against influenza during the period October 1, 2014, to March 31, 2015, will affect payments in 2016.

The proposed 2014 rule adds 4 new measures, to be reflected in 2016 payments:

- complications within 30 days following cataract surgery requiring additional surgery
• improvement in vision within 90 days of cataract surgery
• appropriate follow-up interval for normal colonoscopy
• interval between colonoscopies for patients with previous adenomatous polyps.

Data for these measures are to be reported on the QualityNet website (www.qualitynet.org). However, CMS is asking for input from the industry on alternative methods of data collection, such as through registries or third-party aggregators.

Cataract complications
The reason for increased attention to cataract surgery is that it has become increasingly common, accounting for 2.8 million cases annually in the US. It also has become safer, with a complication rate of 1% to 2%. Because of the high volume, CMS notes, “a 2% rate is significant and translates to over 300,000 surgeries.”

The new quality measure covers retained nuclear fragments, improper size or placement of intraocular lenses, retinal detachment, and other complications in adult patients. Unlike the other 3 new measures, the measure called cataract complications in ASCs has not been endorsed by the National Quality Forum (NQF), a professional group CMS consults in its rulemaking.

While official comments are pending, ophthalmologists in the past have noted that compliance may be impractical for ASCs. Commenting on a pre-rulemaking report issued December 1, 2012, by the Measure Applications Partnership (MAP), the American Society of Cataract and Refractive Surgery (ASCRS) and Outpatient Ophthalmic Surgery Society (OOSS) issued a joint statement saying the measure “reflects a fundamental misunderstanding of the operation of the surgery center.” Compliance, they noted, would require knowledge of the patient’s baseline condition and the ability to follow the patient for 30 days after the surgery. While the surgeon would have access to the patient at those times, the ASC staff would not, and so would not have the information needed to report the quality measure.

Besides, the ASCRS/OOSS statement adds, “these complications would rarely, if ever, be associated with improper care provided by the ASC.”

The groups use a similar argument in their objection to the measure that would report visual acuity following cataract removal. Follow-up examinations occur several times in the month following surgery, they say, but “these refractions are usually performed in the physician’s office and never the ASC.”

Colonoscopy: How often?
The 2 new endoscopy measures would track the frequency of screening colonoscopies based on patient health, age, and risk of disease. The first covers healthy patients, for whom a 10-year interval is currently considered appropriate. The CMS rule states: “Performing colonoscopy too frequently increases a patient’s exposure to procedural harm. This measure aims to assess whether average-risk patients with normal colonoscopies receive a recommendation to receive a repeat colonoscopy in an interval that is less than the recommended amount of 10 years.” The quality report would specify when, following a normal colonoscopy, a patient was advised to have another within 10 years.

The second measure seeks to ensure that patients whose prior colonoscopies revealed adenomatous polyps are encouraged to repeat the procedure every 3 years. For such patients, the ASC would report the number whose previous colonoscopy was more than 3 years ago.

Again, CMS notes that colonoscopies are frequently performed in ASCs.

In a January 28, 2013, letter to the MAP Coordinating Committee, 3 associations agreed with the measures in principle but argued that they are more appropriate for physicians than for ASC facilities.
The American College of Gastroenterology (ACG), the American Gastroenterological Association (AGA), and the American Society for Gastrointestinal Endoscopy (ASGE) joined in: “While this data can inform the quality of care offered by providers at a facility, we are not confident that these clinician-level measures translate into appropriate facility-level measures.”

They urged CMS and NQF to develop more ASC-specific quality measures.

Who reports and when?
The administrative provisions of the proposed rule look much like those in the current rule. For quality reporting, ASCs will be considered compliant if they report on at least 50% of the procedures for which they file Medicare claims. The program originally called for gradual increases in reporting levels, but, at least for 2014, CMS notes that it considers 50% “reasonable.”

CMS has continued the current minimum payment threshold, which exempts from participation, without penalty, any ASC that submits fewer than 240 Medicare claims for the year. Only about 10% of ASCs are in that category, and CMS has agreed that collecting and reporting the additional data would be a burden for them.

The start date for reporting on the additional quality measures is January 1, 2014, but if last year’s precedent is any indication, that date may well change.

When the program began, CMS asked, in its 2011 proposed rule, for reports on the first 7 measures to start on January 1, 2012. ASCs protested that the deadline was impractical, in part because Medicare claim software would have to be updated to reflect the new G-codes designating the quality measures. Later it became evident that many of the Medicare contractors that were processing the new claims also had problems with their software recognizing the new codes. CMS changed the deadline. The first 5 measures were reportable starting October 1, 2012, and the next 4 measures were delayed until sometime in the future.

The July 8, 2013, proposal has a January 1, 2014, deadline, ie, a 2-month window between the November 1 final rule and the start date for reporting. If enough ASCs ask for a later start date, CMS is likely to listen. ✔

—Paula DeJohn

References

DeJohn P. Quality reporting for ASCs is off to a good start. OR Manager. 2013(1):24-26.