



November 1, 2017

2018 AMBULATORY SURGICAL CENTER (ASC) PAYMENT SYSTEM AND QUALITY REPORTING (ASCQR) PROGRAM FINAL RULE RELEASED

2018 ASC Conversion Factor \$45.575 for Those Meeting Quality Reporting Requirements

Today, the Centers for Medicare & Medicaid Services (CMS) issued the Calendar Year (CY) 2018 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Policy Changes and Payment Rates [final rule](#).

ASC Conversion Factor

For CY 2018, CMS adjusted the CY 2017 ASC conversion factor (\$45.003) by the wage adjustment budget neutrality factor of **1.0007 in addition to the MFP-adjusted CPI-U update factor of 1.2%**, which results in a final **CY 2018 ASC conversion factor of \$45.575 for ASCs meeting the quality reporting requirements.**

For ASCs not meeting the quality reporting requirements, CMS adjusted the CY 2017 ASC conversion factor (\$45.003) by the wage adjustment for budget neutrality factor of **1.0007 in addition to the quality reporting/MFP-adjusted CPI-U update factor of -0.8%**, which results in a final **CY 2018 ASC conversion factor of \$44.663 for ASCs not meeting the quality reporting requirements.**

ASC Quality Reporting Program (ASCQR)

CMS finalized adding two measures to the ASCQR measure set for 2022 payment determination and subsequent years.

The two measures are:

- **ASC-17: Hospital Visits after Orthopedic Ambulatory Surgical Center Procedures**, which assesses all-cause, unplanned hospital visits within seven days of an orthopedic procedure performed at an ASC (beginning with the CY 2022 payment determination). For the purposes of this measure, “hospital visits” include emergency department visits, observation stays, and unplanned inpatient admissions.

- **ASC-18: Hospital Visits after Urology Ambulatory Surgical Center Procedures**, which assesses all-cause, unplanned hospital visits occurring within seven days of the urology procedure performed at an ASC (beginning with the CY 2022 payment determination). For the purpose of this measure, “hospital visits” include emergency department visits, observation stays, and unplanned inpatient admissions.

CMS did not finalize the proposed ASC-16: Toxic Anterior Segment Syndrome (TASS) measure, which was supported by ASCRS and others in the ophthalmic community. Citing concerns over the low incidence of TASS and the unlikelihood that the measure will be applicable to most facilities, CMS decided not to implement the measure at this time.

For the CY 2020 payment determination (CY 2018 data collection) and subsequent years, CMS will delay the mandatory implementation of the Consumer Assessment of Health Care Providers and Systems (CAHPS) Outpatient and ASC Survey for CY 2018 Data Collection.

CMS is also finalizing the removal of three current quality measures for 2019 payment determination:

- **ASC-5: Prophylactic Intravenous (IV) Antibiotic Timing**, which assesses whether intravenous antibiotics given for prevention of surgical site infection were administered on time.
- **ASC-6: Safe Surgery Checklist Use**, which is a structural measure of facility process that assesses whether an ASC employed a safe surgery checklist that covered each of the three critical perioperative periods (prior to administering anesthesia, prior to skin incision, and prior to patient leaving the operating room) for the entire data collection period.
- **ASC-7: ASC Facility Volume Data on Selected Procedures**, which is a structural measure of facility capacity that collects surgical procedure volume data on six categories of procedures frequently performed in the ASC setting.

Request for Information on Regulatory Relief

In the proposed rule, CMS released a Request for Information regarding positive solutions to better achieve transparency, flexibility, program simplification and innovation related to outpatient services performed at hospitals and services performed at ASCs. It specifically focused on making the system less bureaucratic and complex, and less burdensome for clinicians and providers, while improving quality of care and reducing costs. ASCRS provided feedback in our comments on the proposed rule, specifically supporting the delay of the use of the CAHPS Survey in the ASC and HOPD because implementing the survey creates both an administrative and financial burden on facilities. CMS noted that the removal of the three quality measures listed above was implemented to provide regulatory relief as part of the new "Patients Over Paperwork" initiative.

Request for Information on a New APC Group for Complex Cataract Surgery

In the proposed rule, CMS requested feedback on whether it should create a new Level 2 Intraocular Procedures C-APC that includes complex cataract surgery, CPT code 66982, and other procedures with similar resources. This would have separated complex cataract services from those identified by CPT 66984. Currently, both procedures are in the same APC group and reimbursed at the same facility rate. ASCRS and the ophthalmic community commented that given the clinical coherence of these procedures and the wide variation in resource costs associated with 66982 and related

services, this is neither necessary nor appropriate. These procedures are clinically homogenous and, therefore, appropriately grouped together with 66984 in the current C-APC. **CMS agreed with this assertion and noted in the final rule it would not go forward with that proposal.**

Comments on Packaging Policies

CMS also solicited comments in the proposed rule on existing packaging policies under the OPPS, including those related to drugs that function as a supply in a diagnostic test, diagnostic procedure, or surgical procedure. It also sought feedback on common clinical scenarios involving separately payable items and services for which payment would be most appropriately packaged. In response to this request for comments, ASCRS noted:

- Concern with the potential bundling of FDA-approved drugs that are administered at the time of cataract surgery—either during or at the end of the procedure—but have an indication for the treatment of post-operative pain and inflammation and/or other sequela of the surgery.
- These medications are not integral or necessary to the cataract procedure and should not be bundled into the facility payment, but instead be separately covered under Medicare Part B. These drugs would take the place of post-operative drops that are currently separately covered under Medicare Part D.
- CMS has issued sub-regulatory guidance that prohibits separate payment for compounded drugs, and we are concerned that branded products in the pipeline for FDA approval will be treated similarly, which would render it virtually impossible for Medicare beneficiaries to access these treatment options.

CMS thanked commenters for their feedback on the request for information and will take recommendations into future consideration.

Additional information will be detailed in upcoming editions of *Washington Watch Weekly*. For questions, please contact Allison Madson, manager of regulatory affairs, at 703-591-2220 or amadson@ascrs.org.

[ASCRS Home](#) | [ASCRS Government Relations](#) | [Contact Us](#) | [Unsubscribe](#)

4000 Legato Road, Suite 700
Fairfax, VA 22033
703-591-22201